Kentucky Department for Medicaid Services

Drug Review Decisions

(UPDATED 2/27/03)

The following chart provides a summary of the recommendations that were made by the Pharmacy and Therapeutics (P&T) Advisory Committee at the February 6, 2003, meeting and the final decisions made after review of the recommendations.

	Description of Recommendation	**Final Decision by the Commissioner and the Secretary – February 14, 2003**
#1	• Place Zyrtec liquid 5mg/5ml with a quantity limit of 150ml/ month, and loratadine OTC (e.g. Alavert, Claritin, generic loratadine) on the Preferred Drug List. • Place a prior authorization requirement on Allegra (all strengths), Allegra-D (All Strengths), Clarinex (all strengths and dosage forms including any future decongestant combination products), Zyrtec tablets (all strengths), and Zyrtec liquid 10mg/10ml. • Continue the current status of the remaining first-generation antihistamines and quantity limits.	Recommendation Approved
#2	• Approval of any single agent non-preferred non-sedating antihistamine will be based on evidence of a therapeutic failure of a 30-day trial of loratadine within the previous 12 months. This will be implemented using an electronic claims step edit.	Recommendation Approved
#3	• Approval of combination products (e.g. Zyrtec-D, Allegra-D) will be based on a diagnosis of Seasonal Allergic Rhinitis or Perennial Allergic Rhinitis and failure of at least a 30 day trial within the past 120 days with Claritin (loratadine), Zyrtec (cetirizine), Allegra (fexofenadine) or Clarinex (desloratadine), or a 30 day trial of an intranasal corticosteroid within the same 120 day period.	Recommendation Approved
#4	For Celebrex, Vioxx, and Bextra; the following prior authorization criteria apply: Prior authorization is not required for recipients 60 years of age and older. For recipients under the age of 60, prior authorization will be granted if: · The recipient has a history of a documented gastric or duodenal ulcer, or H. Pilori infection; · The recipient has a history of an endoscopically documented nonsteroidal anti-inflammatory drug (NSAID) induced gastritis with hemorrhage, or · The recipient must concurrently receive a corticosteroid, warfarin, or DMARD drug; or · The recipient has had two failed trials of other NSAIDs (at an approved prescription dosage) that were due to a lack of tolerability; or · The recipient has a significant comorbidity that would predispose to adverse outcomes in the setting of a gastrointestinal hemorrhage, perforation or obstruction. Prior authorization for celecoxib (but not rofecoxib) will be granted for recipients with a diagnosis of familial adenomatous polyposis. PA may be authorized for up to 12 months in these situations.	Recommendation Approved
#5	• Vioxx (rofecoxib) 50mg may be approved for a 5 day maximum only	Recommendation Approved